Authorization to Release Information to Third Party

Life Insurance Company of North America
Connecticut General Life Insurance Company
New York Life Group Insurance Company of NY

GROUP BENEFIT SOLUTIONS

I, _____ ("I" or "you") hereby authorize _____ or any of its affiliated companies ("Company") to furnish _____ or any Agent/Broker working on behalf of _____ any and all information with respect to my claim under policy/plan number _____ ("Plan"), including information about my health that may relate to any disorder of the immune system including but not limited to HIV and AIDS; use of drugs or alcohol; communicable diseases; and mental and physical history, condition, advice or treatment, but not including psychotherapy notes.

A copy of this authorization shall be considered as effective and valid as the original. I understand that I, or my authorized representative, will receive a copy of this authorization upon request by writing to the Company Claim Manager handling my Plan claim.

I understand that this information will be used for the purpose of _____

I understand that this authorization is valid up to one year from the date of signature and that I may be asked to complete an additional authorization form after that date if I wish disclosures to continue.

I understand this authorization is voluntary, I do not have to give this authorization, and if I choose not to give it - or later revoke it - I understand that my eligibility for, and payment of, Plan benefits will not be affected.

Completed forms shall be sent to the Claim Manager handling my Plan claim. I, or my authorized representative, may revoke this authorization, at any time, by writing to the Company Claim Manager assigned to my Plan claim. Any such revocation received by the Company shall apply to future disclosures and shall not affect any action Company took on the authorization before Company received the revocation.

The records held by us and disclosed pursuant to this authorization are not governed by the Health Insurance Portability and Accountability Act ("HIPAA"), and once disclosed as authorized, their use and further disclosure may also not be subject to HIPAA.

Dated: _____ Signature: _____

If applicable, I signed on behalf of the claimant as _____ (indicate relationship).

If signing as power of attorney, guardian, or conservator, please attach a copy of the document granting authority. If you are under 18 years of age or incapacitated, the parent or guardian must sign. If the Plan claimant is deceased, the personal representative or executor of the claimant's estate must sign.